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| **DEPRIVATION OF LIBERTY SAFEGUARDS FORM 5****STANDARD AUTHORISATION GRANTED** |
| Full name of person being deprived of liberty |  | Sex |
| Date of Birth (or estimated age if unknown) |  |
| **Person to contact and details of Supervisory Body:** |
| Name |  |
| Address (including ward if appropriate) |  |
| Telephone |  |
| Email |  |
| Usual address of the person liable to be deprived of liberty, (if different to above) |  |
| Telephone Number |  |
| Name and address of the Managing Authority where this form is being sent |  |
| Details of Care Co-ordinator/Care Manager |  |
| Communication Needs and any relevant medical history |  |
| **THE SUPERVISORY BODY’S DECISION** |
| This standard authorisation is to come into force on:Date: Time:  |
| This standard authorisation is to expire at the end of the day on:Date: Time:  |
| The reasons for this period are:(The period specified must not exceed the maximum period specified in the best interests assessment) |
| **THE *AUTHORISATION***is to enable the following care or treatment to be given in the hospital or care home. |
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| **CONDITIONS TO WHICH THE STANDARD AUTHORISATION IS SUBJECT:** |
| This standard authorisation **IS NOT** subject to any conditions. |  |
| This standard authorisation **IS** subject to the following conditions set out immediately below. |  |
| 1 |  |
| 2 |  |
| 3 |  |
| 4 |  |
| **Any additional conditions placed by the Supervisory Body authoriser** |
| 5 |  |
| 6 |  |
| The care home or hospital staff must comply with these conditions. (The Supervisory Body should consult the Best Interests Assessor if their recommendations are not being followed and they have indicated in their assessment report that they would like to be consulted again in that event, since some of the other conclusions that they have reached in their assessment may be affected). |

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| **The authorisation is granted because the Supervisory Body has received written copies of all required assessments and concludes each requirement met**  |

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| **EVIDENCE OF SUPERVISORY BODY SCRUTINY** |
| The authoriser should indicate why they concur with the conclusions of the assessors reports and demonstrate overall scrutiny of the process: |
| **PLEASE NOW SIGN AND DATE THIS FORM (*to be signed on behalf of the Supervisory Body*)** |
| Signature  |  | Print Name |  |
| Position  |  |
| Date |  | Time |  |
| **APPOINTMENT OF A REPRESENTATIVE - 1st copy to be retained by representative** |
| **Details of the person to be appointed**The Supervisory Body appoints the person named below to represent the relevant person, in so doing it confirms that they meet the eligibility requirements of the Deprivation of Liberty Safeguards provisions of the Mental Capacity Act 2005. This person was identified as representative by: |
| The Relevant Person |  |
| The Best Interests Assessor |  |
| The Best Interests Assessor indicated that they were not able to select an eligible person as representative. It is therefore necessary for the Supervisory Body to select a representative for this person. |  |
| Full name of Relevant Person’s Representative |  |
| Address |  |
| Telephone |  |
| Email |  |
| Relationship to Relevant Person |  |
| This appointment lasts for the same period as the Standard Authorisation to which it relates. |

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| **APPOINTMENT OF A REPRESENTATIVE** **2nd copy – to be returned to Supervisory Body** |
| **Details of the person to be appointed**The Supervisory Body appoints the person named below to represent the relevant person, in so doing it confirms that they meet the eligibility requirements of the Deprivation of Liberty Safeguards provisions of the Mental Capacity Act 2005. This person was identified as representative by: |
| The Relevant Person |  |
| The Best Interests Assessor |  |
| The Best Interests Assessor indicated that they were not able to select an eligible person as representative. It is therefore necessary for the Supervisory Body to select a representative for this person.  |  |
| Full name of Relevant Person’s Representative |  |
| Address |  |
| Telephone |  |
| Email |  |
| Full name of Relevant Person |  |
| Relationship to Relevant Person |  |
| This appointment lasts for the same period as the Standard Authorisation to which it relates. |
| **Agreement of the appointed representative:**I am willing to be appointed as this person’s representative under the Deprivation of Liberty Safeguards provisions of the Mental Capacity Act 2005 and I am aware of the functions that I am expected to perform |
| **Signed** |  |
| **Date** |  |

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| **Please now return this page only to the Supervisory Body indicated below** |
| Name and address of the Supervisory Body  |  |
| Person to contact at the Supervisory Body | Name |  |
| Telephone |  |
| Email |  |